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RESTORING HOPE IN SUBSTANCE-USING TEEN WITH LEARNING DISABILITIES

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Warren was a 17½ year old senior who had been diagnosed as "high-functioning Asperger's." He started smoking pot at the beginning of the 11th grade. Ten days prior to our first meeting, he had tried to commit suicide by overdosing on an over-the-counter cold medication at a mountain retreat with his high-school class.

> The essential features of Asperger's Disorder are severe and sustained impairment in social interaction…and the development of restricted, repetitive patterns of behavior, interests, and activities. The disturbance must cause clinically significant impairment in social, occupational, or other important areas of functioning (DSM-IV, p. 75).

Adolescents with Asperger's often become experts in arcane subjects like dinosaurs or prehistoric sharks, about which they can talk endlessly, totally oblivious to the yawns and bored expressions of their families. I didn't say family *and* friends, because these kids frequently don't have friends. As with every disorder, there is a continuum. Teens with severe Asperger's are usually not at risk for drugs precisely because they often have little interest in social contacts outside their families. Warren, on the other end of the continuum, in addition to being highly intelligent, deeply longed for friendships. His bliss was computers—an interest with a reasonably high social index. However, he couldn't read social cues deftly or modify his communication style to fit the changing moods of his peers. Such things were like foreign languages to him.

The suicide attempt and marijuana use may have been the event that caused Warren's parents to seek counseling for their son, but his lack of friends was to become the subject of much of our work together. That was the developmental task at which he was not succeeding and it needed some concentrated focus and support. It turned out to be the reason he had tried to kill himself. It turned out to be the main reason he smoked pot: As with many kids with low social competence or confidence, smoking pot provided access to a network of friends who would accept him, simply because he smoked pot, too.

As with all teens, with or without learning disabilities (LD), if you're going to ask them to give up something like pot or alcohol that not only gives pleasure, but sooths or even helps temporarily alleviate some of their symptoms, you'd better be prepared to offer something they perceive as even more wonderful.

Pedagogic vs. Therapeutic Interventions

Mel Levine, arguing for "schools for all kinds of mind," describes ideal teachers as "front-line experts on mind development and learning in the age group(s) they work with." They should be "knowledgeable about the highly specific neurodevelopmental functions required for success in these realms and the differences in learning that teachers are likely to encounter among any cohort of students" (p. 308).

In the same spirit, counselors benefit from having a solid understanding of the developmental tasks adolescents are trying to master in order to assess which tasks are being mastered and which are not. Warren did not volunteer how much he longed for friendship. It's been my experience that teenagers in general tend to require more proactivity on the part of a counselor. That a healthy, good-looking teenager on a retreat with classmates would try to kill himself certainly raises questions about his ability to foster meaningful peer relationships—a critical developmental task. One of my favorite questions is, "Can I ask you a question?" The answer is almost always a grateful, "Yes."

Substance abuse counselors working with teens with LD face unique challenges. It helps to be able to interface knowledgably with as many treatment domains as you can: family, social, school, as well as the intrapersonal world of the unique individual before you.

Defining LD

The Individuals with Disabilities Education Act (IDEA) defines a learning disability as:

> [A] disorder in one or more of the basic psychological processes involved in understanding or in using spoken or written language, which may manifest itself in an imperfect ability to listen, think, speak, read, write, spell or to do mathematical calculations.

Mental retardation is not a learning disability. It's a whole other category. Kids with LD can range from average intelligence to off-the-chart brilliant. The term "learning differences" is currently being substituted for "learning disabilities" in many academic milieus to avoid the disempowerment inherent in the word "disabilities."

The study of learning differences, their identification and remediation, is rich and varied. At one time, the statement "The treatment of learning disabilities is primarily pedagogic" (Jansky, p. 306), was axiomatic. I believed it, too, until I became a counselor at a private school for kids with learning differences and found myself speaking to the profound emotional challenges and wounding that LD can bring in its wake.

Recent research even argues that the attributes of "self-awareness, proactivity, perseverance, goal setting, and the use of effective social support systems, and emotional coping strategies are more predictive of [future] success than are academic skills" (Goldberg et al., p. 234); or even IQ, and the effects of life stressors, age, gender, ethnicity or socioeconomic status (Raskind et al.).

When the LD Is ADHD

Much of the research that positively correlates learning disabilities with Adolescent Substance Use Disorder (ASUD) specifically correlates Attention Deficit Hyperactivity Disorder (ADHD) to substance abuse. One study calculates that nearly half of adults with ADHD have a comorbid drug use disorder (Johann), and "at least 50 percent of all kids with Conduct Disorder also have ADHD" (Koplewicz, p. 206). Alcohol researchers cite a high correlation between the ADHD temperament (impulsive, overactive, difficulty focusing attention at will) and substance abuse, and warn that people with ADHD who develop addictions often started using during adolescence

(Hallowell & Ratey).

Treated vs. untreated ADHD: A study at Harvard University found that 52% of adults with untreated ADHD abuse drugs or alcohol. Their drugs of choice are alcohol and marijuana to settle feelings of restlessness, and cocaine and methamphetamines to help them become more energetic and focused (Amen). Treated adolescents and adults with ADHD conform to substance use trends for non-ADHD populations.

Recognizing self- medication: Samuel was an 18 year old who had successfully abstained from pot in order to get a marijuana possession charge dismissed in court. He confessed to imagining returning to "controlled use" when he started classes at a community college in the fall. This is what he described: one hit in the morning with his coffee in order to wake his mind up and help him focus. Sam loved to learn, but his high intelligence was not reflected in his high-school GPA. As we explored how his "controlled use" might be a form of self-medicating, he went on to describe classic ADHD challenges throughout school: difficulty waking his mind up; difficulty shifting attention and holding a focused beam of concentration at will; easily distracted; and highly erratic academic performances over the course of a school year.

In Sam's case, identifying prescribed ADHD medications, with more controlled side effects, proved to be an effective prophylactic against his return to daily pot use. "Let's see," Sam concluded laughingly. "Here's just what a student needs: Wake up my mind with THC, lose my memory with THC. Some trade-off!"

Creating a Container

When you're looking at middle- or high-school teenagers, usually ranging in ages 13 to 18 years old, you're looking at individuals, to be sure. More descriptively, however, you're looking at individuals in the process of emerging from and differentiating within a composite of protective matrices—"holding environments" (Winnicott) or "containers," if you will. Primary containers are the families in which they reside until they are emotionally and legally ready to emancipate. Other containers are schools, neighborhoods and even peer groups.

The literature of LD consistently stresses two needs that fall within the domain of counseling: 1) the need for positive reinforcement to bolster the child's sagging self-esteem and revitalize hope and create a spirit of optimism. Only an optimistic mind is an open mind capable of learning; and 2) the need for structure. All children benefit from an orderly, predictable, and reliable environment. I like to describe a good container as one that breathes with adolescents: expanding when they fulfill their obligations and express through positive personal and social outlets; and contracting as a consequence of unacceptable or destructive choices. Ideally, the primary container is the family and is maintained by the family. Sometimes the family needs to be fortified by the school, or even a probation officer, requiring that this teen show clean UA's in order to return to class, or resolve a legal mandate.

A meta-analysis and literature review conducted in 1997 (Stanton and Shadish) found that family therapy is superior to other modalities in treating ASUD and can enhance the effectiveness of other forms of treatment as well. Family therapy was specifically differentiated from family psychoeducation and support groups. Among the family therapies that have strong theoretical bases, structural-strategic family therapy was found to be effective in reducing drug use among adolescents (Weinberg et al.)

As kids with LD can be slower to internalize an experience of structure, a paradox frequently emerges: How to create more structure without making your LD teen feel like a child? My favorite counseling mantra is, "Treatment is in the details." Helping parents really get to know their maturing son or daughter, while helping to fine-tune the container can be uniquely challenging as ADHD, for example, has a high heritability. Often one (or even both) of the parents is as LD as their child.

Once teens with LD have moved into the action stage of their recovery, peer group counseling can offer another dynamic container, but often not before—especially for teens with ADHD and conduct problems.

A Balancing Act

Bolstering self-esteem and fortifying the family structure, in my experience, are best done simultaneously. For that reason, my first meeting is usually with teens and their parents. After hearing about "the presenting problem," I will shift gears and ask teens about their interests, hobbies and favorite subjects in school. I am looking for strengths. I want to witness them in the presence of the parents. If the teen is bright, well spoken and possessed of a powerfully dominating personality (which is not uncommon among ADHD kids that end up in counseling), I often compose a reframe that will specifically value those qualities. For example, many leaders and CEO's with high dominating indexes were once kids with high dominating indexes.

The field of vocational guidance counseling offers a useful scaffold for this kind of intervention. For example, D.E. Super's theories about life-span development, roles and values can help the counselor listen for what this troubled kid sitting before you uniquely values. Is she a risk taker? Is she interested in making money? Is she wired for physical activity or aggression, power, creativity, aesthetics, achievement, or social interaction? Identifying such qualities and reflecting them back to unfocused teenagers can be almost like an awakening for them; a second birth, if you will.

Not infrequently, kids with LD are "monolithically" organized: for example, extremely kinesthetic; heavily concentrated in a specific temperament function as described in the Meyers-Briggs type inventory (feeling, thinking, intuitive, sensate, extravert, introvert); very passionate about a specific activity or subject such as snowboarding, computers, cars, music, drawing, or animals. When a teen with LD really gets the idea that it's okay, even strategic, to rejoice in their strengths, you can often start to wrap this around the mid- to late-adolescent developmental task of beginning to imagine an application for this strength: a life's dream or career. A dream can serve as an incredible ordering device. Where there was chaos, now there's a path. Following a path requires the ability to focus. It also strengthens it.

Gradually, these teens begin to see themselves not as patchworks of deficits, but as whole persons with strengths and weaknesses just like the rest of us. In life, we all try to maximize our strengths and get "good enough" at our weaknesses to get by. If our weakness is math, we may never become engineers, but at least we can balance our checkbooks and accurately count our cash. This concept of getting good enough at a deficit is one I carry into my collaborations with teachers. Once teens with LD get the idea that a weakness like math, for example, might be useful to strengthen, they can become collaborators in all the effective pedagogic remediations special-education offers.

I like the analogy of a hungry yet furious infant: Before he can eat, he's got to be soothed. Before a teen with LD can learn, he's got to accept an invitation to the table.

Sometimes the teacher needs to be soothed, too. Brian was a 7th grader with ADHD. He had never completed a single year in one school before being sent back to home schooling. His parents were trying as a last resort the school at which I was counselor. Half way through the school year Brian's teacher was in despair because he could be so dominating as well as inattentive; plus his reading scores weren't going up. What I saw was that he was still in school, making friends (though he was loath to admit it), and actively testing a container that he realized was able to bear him. With this reframe, the teacher realized how much she was actually accomplishing. Her stress level went down and she was able to reengage this student positively.

Reality Processing

Once all the containers are in place and breathing properly; that is, justly and decisively responsive to choices the teen makes, I can join the teen in processing the reality principle—all those forces of life that appear to run counter to our immediate pleasures, such as parents and school demanding clean UAs.

In using this strategy, the counselor actually piggybacks on a developmental challenge with which teens are dealing by virtue of being adolescents. August Aichhorn, a psychologically trained director at state institutions for "delinquent" boys in Austria circa 1910 observed: "We can define the different stages of the child's development according to the degree in which the pleasure principle predominates over the reality principle" (p. 190). One of the tasks of adolescence is to learn how to balance these great life forces. To become successful adults, the locus of control must move from external structures to within each of us.

Identifying and being true to a personal way of life is a high priority for adolescents. The only way I've ever found people give up pleasures that have become problematic is to find something they value more—and believe they can attain. For teens with LD, this can mean discovering ways to be successful in school while remaining authentic and true to their strengths and passions. Learning becomes meaningful and personally relevant because it is no longer perceived as shaming, but a means of empowering the adult they hope to become.

When the choice between self-empowerment and the false solutions inherent in substance abuse become clarified, it can be a wonderful thing to watch a teen with LD discover the truer path.

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